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ABSTRACT

Each year, thousands of children in child care settings are injured seriously enough to need emergency medical treatment. This national study identified potential safety hazards in 220 licensed child care settings in October and November 1998. Eight product areas were examined: cribs, soft bedding, playground surfacing, playground surface maintenance, child safety gates, window blind cords, drawstrings on children's clothing, and recalled children's products. Participating child care centers were located in the eastern, central, or western United States and were selected randomly, when possible, from regional or national lists of licensed child care providers. A prepared checklist was used to observe conditions related to the eight product areas. The findings indicated that two-thirds of the child care settings exhibited at least one of the targeted safety hazards. The most commonly seen hazards were the use of clothing with drawstrings at the neck (38 percent of settings), lack of safe playground surfacing (24 percent) or adequate maintenance (27 percent), and the use of window blind cords with loops (26 percent). Fewer settings had cribs that did not meet current safety standards (8 percent), cribs with soft bedding (19 percent), lack of child safety gates (13 percent), and the use of recalled products (5 percent). A review of state licensing requirements revealed that most of the hazards examined in this study are not adequately addressed. (KB)

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CPSC Consumer Product Safety Commission

CPSC Staff Study of

Safety Hazards in Child Care Settings

U.S. Consumer Product Safety Commission
Washington, D.C. 20207
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Overview

- The U.S. Consumer Product Safety Commission (CPSC) staff conducted a national study to identify potential safety hazards in 220 licensed child care settings across the country in October and November 1998.
- CPSC staff investigated eight product areas with potential safety hazards: cribs, soft bedding, playground surfacing, playground surfacing maintenance, child safety gates, window blind cords, drawstrings in children's clothing, and recalled children's products.
- Four types of licensed child care settings were visited: federal General Services Administration child care centers, non-profit centers, in-home settings, and for-profit centers.
- Overall, two-thirds of the child care settings exhibited at least one of the safety hazards targeted in the study.
- About 31,000 children, 4 years old and younger, were treated in U.S. hospital emergency rooms for injuries at child care/school settings in 1997. CPSC is aware of at least 56 children who have died in child care settings since 1990.

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Introduction

CPSC has long been concerned about hazards in the home, especially as they affect young children. Because similar hazards may be present in organized child care settings, CPSC staff conducted a national study of potential dangers in these settings to identify how to help prevent injuries and ensure greater safety for children.

Some hazards are obvious -- like playground surfacing that has worn thin and is littered with debris. Other hazards are "hidden" -- dangers that may not come immediately to mind as problems. Issues investigated in the child care study -- like the dangers of window blind cords or drawstrings on children's clothing -- are prime examples of hidden hazards.

Many child care settings provide safe environments for young children. Each year, however, thousands of children in child care settings are injured seriously enough to need treatment in U.S. hospital emergency

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rooms. Tragically, some of these children die from their injuries.

For example, CPSC is aware of at least 56 children who have died in child care settings since 1990. At least 28 of these children died from suffocation and/or asphyxia related to nursery equipment or soft bedding. About 31,000 children, 4 years old and younger, were treated in U.S. hospital emergency rooms for injuries at child care/school settings in 1997. Eight thousand of these injuries occurred from falls on playgrounds.

Background

There are 21 million children under age 6 in this country; almost 13 million of them are placed in non-parental child care during some portion of the day. About 29% of these children are in center-based care, including day care centers, Head Start programs, and nursery schools. The other 71% of these children are in non-center-based care, including family child care, in-home child care, and care by a relative.

There are about 99,000 licensed child care centers. In addition, there are about 283,000 regulated or licensed family child care providers. In CPSC staff's review of state licensing requirements for child care, however, most of the hazards included in this child care study were not addressed. For example, although cribs are covered by both federal regulations and voluntary safety standards, many states did not require day care centers to use cribs that met all of these standards. Although virtually all child care settings use nursery equipment, like high chairs and strollers, none of the states reviewed had requirements for addressing recalled nursery equipment.

Description of Study

CPSC staff conducted a national study to identify potential safety hazards in child care settings during October and November of 1998. Eight product areas were examined, including: cribs, soft bedding, playground surfacing, playground surface maintenance, child safety gates, window blind cords, drawstrings on children's clothing, and recalled children's products.

CPSC staff visited 220 licensed child care settings throughout the country. Four types of settings were visited: 23 Government Services Administration (GSA)-managed child care centers, sponsored by Cabinet-level and independent federal agencies; 77 non-profit centers; 68 in-home settings; and 52 for-profit centers.

These child care settings were spread across three regions of the country: eastern (68), central (71), and western (76). Within each region, about 10% of the child care settings were GSA-sponsored; 40% were non-profit; 30% were in-home; and 20% were for-profit.

Where possible, participating child care settings were selected randomly from regional or national lists of licensed child care providers. When such lists were not available, selections were made from a variety of other sources, including Internet sites and local yellow pages.

CPSC field staff used a prepared checklist to observe conditions related to the eight product areas. Information from the checklists was entered into a database for further analysis.

Results of Study

Two-thirds of the child care settings in this study exhibited at least one of the targeted safety hazards. The

overall results for each hazard are discussed below. To see how each different type of child care setting fared in this study, please refer to the associated chart.

- **CRIBS: 8% of the child care settings had cribs that did not meet current safety standards.**

  Older cribs can present many dangers to children, including strangulation and suffocation.

  More babies -- about 40 to 50 each year -- die in incidents involving cribs than with any other piece of nursery equipment. Most of these are older, used cribs. Since 1990, at least nine children have died in incidents involving cribs in child care settings. Children can strangle when their bodies slip between crib slats that are too far apart and their heads catch in the slats. Children can suffocate when their faces and noses are wedged between a too-small mattress and the crib. There also can be problems when used cribs are not sturdy or have catchpoints that can entangle children's clothing. In related nursery equipment, playpens have been involved in the deaths of at least eight children at child care centers since 1990.

  CPSC enforces federal regulations on crib safety and has actively worked to develop and improve voluntary safety standards for cribs and playpens.

- **SOFT BEDDING: 19% of the child care settings had cribs containing soft bedding.**

  Soft bedding may present a suffocation hazard for infants.

  Each year, as many as 900 babies whose deaths are attributed to Sudden Infant Death Syndrome (SIDS) may have suffocated on soft bedding.

  CPSC staff brought national attention to this issue by publishing a report in 1995 that linked soft bedding in cribs -- like quilts, comforters, and pillows -- with possible infant suffocation. In April 1999, CPSC recommended eliminating all soft bedding in babies' cribs to prevent deaths.

- **PLAYGROUND SURFACING: 24% of the child care settings did not have safe playground surfacing.**

- **PLAYGROUND MAINTENANCE: 27% of the child care settings did not keep the playground surfacing well-maintained.**

  Young children can be seriously hurt from falls on playgrounds.

  For children under 6, playground-related injuries (about 90,000 each year) account for more visits to U.S. hospital emergency rooms than any other child care-related injury. About 15 children die each year from playground-related injuries, including at least three children on playgrounds at child care settings since 1990. Most injuries occur when a child falls from the equipment onto the ground. Fractures are the most commonly reported diagnosis, accounting for about one-third of the injuries. Injuries most often involve the head and/or face (37%) and arm and/or hand (37%).

  To help protect children from serious injuries, especially head injuries, safe playground surfacing should have at least 12 inches of wood chips, mulch, sand, or pea gravel, or should be mats of safety-tested rubber or rubber-like materials. In addition, the surfacing should be properly maintained. CPSC staff found that playground surfacing at some child care settings included dirt, grass, bricks, asphalt, and thinly-laid wood chips over concrete -- all surfaces that will not protect

children when they fall.

CPSC developed playground safety guidelines, which are widely used throughout the country, to design, construct, operate, and maintain safe public playgrounds.

- **CHILD SAFETY GATES: 13% of the child care settings did not use child safety gates where necessary.**

  Child safety gates can protect children from hazards, especially falls down stairs.

  Safety gates can prevent a wide range of injuries. For example, in 1997, over 100,000 children under 5 went to U.S. hospital emergency rooms with stair-related injuries. Many of these injuries might have been prevented had safety gates been used.

  CPSC helped develop a voluntary safety standard for child safety gates.

- **WINDOW BLIND CORDS: 26% of the child care settings had loops on the window blind cords.**

  Children can strangle in the loops of window blind cords.

  About one child a month strangles in window covering cords. Many strangulations occur in the loop of the cords. At least two children since 1990 have died in child care settings after standing up in their cribs and becoming entangled in a window blind cord.

  Because of CPSC's work with industry, all loops on mini-blind cords have been eliminated. CPSC also advises that child care providers with older mini-blinds or venetian blinds cut the looped cord, remove the buckle, and put a safety tassel on each cord. Older vertical blinds and drapery cords should have tension or tie-down devices to hold the cords tight. When buying new window coverings, child care providers should ask for child safety features. For additional safety, cribs should not be placed near windows.

- **CLOTHING WITH DRAWSTRINGS: 38% of the child care settings had children wearing clothing with drawstrings at the neck.**

  Drawstrings on clothing can catch on objects and strangle a child.

  Since 1985, CPSC has received reports of at least 22 deaths and 47 non-fatal incidents caused by drawstring entanglement. At least one death since 1990 occurred at a child care location where a drawstring on a child's piece of clothing caught on playground equipment.

  As a result of CPSC negotiations with industry, manufacturers have agreed not to include drawstrings at the neck of children's upper outerwear clothing and now adhere to a voluntary safety standard.

- **RECALLED PRODUCTS: 5% of the child care settings had products that had been recalled by CPSC.**

  Using recalled nursery products and toys can be a hazard to young children.

CPSC is aware of at least three children in child care settings since 1990 who have died in incidents involving children's products recalled by CPSC. In each of these instances, a portable crib/playpen was involved in the deaths.

Removing potentially dangerous children's toys and products from the marketplace and people's homes is a top CPSC priority. In 1998, for example, CPSC conducted about 100 recalls (or about a third of all CPSC recalls) that involved more than 30 million children's products. If notices of recalled children's products were regularly posted or distributed in child care settings, caretakers and parents would be better able to prevent deaths and injuries. Some of the CPSC-recalled products found at child care settings included toys, cribs, and bean bag furniture.

Conclusion:

After observing 220 child care settings across the United States, CPSC staff found that most of these settings (two-thirds) had at least one of the safety hazards targeted in this study. That means that children in these settings may be at risk of injury or death.

CPSC staff's review of state licensing requirements indicates that most of the hazards included in the study are not adequately addressed in these requirements. In many cases, it is likely that well-intentioned child care providers and parents are not aware that many of the hazards exist.

To help remedy this situation, CPSC staff prepared a "Child Care Safety Checklist for Parents and Child Care Providers." The checklist is easy to use -- with just eight points that should be examined in every child care setting. In addition, parents may want to use the safety checklist at home.

Nothing is more important than the safety of America's children. More of our young children die from injuries than from any disease. Because so many children are in child care at some point in their life, it is essential that these settings be as safe as they can be.